STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	C 11/16/2023

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MILL CREEK CENTER FOR NURSING AND REHABILITATION	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 11/13/23 through 11/16/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3E8P11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey were conducted from 11/13/23 through 11/16/23. The following intakes were investigated NC00198035, NC00201334, NC00201781, NC00201973, NC00202372, NC00203775, NC00203858, NC00205493, NC00206606, NC00207671, and NC00209551. 6 of the 38 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity J Immediate Jeopardy began on 11/14/23 and was removed on 11/15/23. An extended survey was not conducted.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment related to the Preadmission Screening and Resident Review	F 641	Regarding the alleged deficient practice of an assessment not accurately reflecting a resident's status by: - Failing to accurately code the	12/16/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/15/2023

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F 641	Continued From page 1 (PASRR) Level II status for 1 of 1 resident (Resident #37) reviewed with a PASRR Level II determination. The findings included: Resident #37 was admitted to the facility on 6/2/22 with cumulative diagnoses which included a history of cerebral infarction (a type of stroke which occurs when blood flow to the brain is disrupted), vascular dementia, recurrent major depressive disorder, and anxiety disorder. A review of Resident #37's electronic medical record (EMR) included a state Medicaid Uniform Screening Tool (NC MUST) form dated 7/2/22. This form indicated a Preadmission Screening and Resident Review (PASRR) was completed. Resident #37's PASRR number ended with the letter "B," which was indicative of a PASRR Level II determination with no limitation on the timeframe. The results of the evaluation, including the determination of a PASRR Level II status, were used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care. Resident #37's most recent comprehensive Minimum Data Set (MDS) was an annual assessment dated 6/1/23. The "Identification Information" section of this MDS assessment did not report Resident #37 had a PASRR Level II determination. Further review of the resident's EMR revealed his care plan included the following area of focus, in part: Resident has a Level II PASRR related to serious mental illness/related condition due to	F 641	Minimum Data Set (MDS) assessment related to the Preadmission Screening and Resident Review (PASRR) Level II status for 1 of 1 resident (Resident #37) reviewed with a PASRR Level II determination. Minimum Data Set Coordinator (MDS) Nurse corrected the inaccuracy of Resident #37's annual assessment from 6/1/23 to reflect the accurate PASRR Level II determination status on 11/16/23. The Minimum Data Set Nurse who created the assessment is no longer employed at the facility. The current Minimum Data Set Nurse was educated by the Regional MDS Director on 12/14/23 to accurately code a resident's PASRR on the MDS. All residents have the potential to be affected. By 12/16/23, the MDS Nurse will conduct a full audit of current in-house residents to ensure their PASRR level status matches active MDS assessments. The Admissions Concierge will review all new admission PASRR levels at the time of admission and provide the level status to the Interdisciplinary Team to review in the IDT meeting. Administrator or designee to audit 5 MDS assessments weekly x 4 weeks then 5 MDS assessments monthly times 3 months to ensure resident PASRR accuracy. Administrator will review the plan during Quality Assurance committee meetings	

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F 641	Continued From page 2 vascular dementia, recurrent major depressive disorder and anxiety. This area of focus was initiated on 10/20/23. An interview was conducted on 11/16/23 at 12:50 PM with the facility's MDS Coordinator. Upon review of Resident #37's EMR, the MDS Coordinator confirmed the resident was determined to have PASRR Level II status. The MDS Coordinator reported the 6/1/23 annual MDS assessment was inaccurately coded and should have indicated Resident #37 was a PASRR Level II resident. She stated the error needed to be corrected.	F 641	times 3 months and continue audits at the discretion of the committee.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		12/16/23

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F 657	Continued From page 3 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to invite a resident (Resident #30), who was his own responsible party, to a care plan meeting quarterly. This occurred for 1 of 23 residents reviewed for resident specific care plans. The findings included: Resident #30 was admitted to the facility on 1/27/2022. A review of the quarterly Minimum Data Set (MDS) dated 10/11/2023 revealed Resident #30 was cognitively intact. A review of the electronic medical record for Resident #30 documented a care plan meeting was conducted in March 2023. There was no documentation for a care plan meeting after March 2023. An interview was conducted with Resident #30 on 11/14/2023 at 10:17 a.m. and he stated he had not been invited to a care plan meeting in a long time. He was unsure of the date of the last care plan meeting and added it was possibly last winter. An interview was conducted with the Admission Concierge on 11/15/2023 at 12:16 p.m. and she	F 657	Regarding the alleged deficient practice of the failure to invite a resident to a quarterly care plan meeting for 1 of 23 residents as evidenced by: - Resident #30 is his own responsible party and was not invited to his quarterly care plan meeting in March 2023. The newly hired Social Services Director and Concierge were educated on 12/15/23 by the Administrator to schedule all care conferences and invite the resident and or the resident's representative to participate in the meeting. Education included how to run care conferences, form of discussion, documentation, who needs to be involved, and how often to schedule. The Social Services Director or Concierge will then document the attendance with an explanation in the resident's medical record if it is determined that attendance is not practicable for the development of the resident's care plan. All residents have the potential to be affected. On 12/14/23, the Social Services Director audited all upcoming resident quarterly care conferences in the next 30 days to ensure they have been invited to ensure no other residents are affected.	

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F 657	Continued From page 4 stated she was responsible to schedule all new admission care plan meetings, and the social worker (SW) would schedule the quarterly meetings. She revealed the facility does not have a current SW. She reviewed the medical record for Resident #30 and stated the last care plan meeting she located was from March of 2023. She revealed they had been without a SW for one week and was unsure who was responsible for scheduling the meetings in her absence. An interview was conducted with the Administrator on 11/15/2023 at 12:32 p.m. and she stated the Admission Concierge schedules the care plan meetings and the SW previously scheduled the meetings. She added it was her expectation that the care plan meetings occur upon admission and quarterly. She also expected a resident to be invited to the meeting.	F 657	Administrator will audit care conferences times 3 days for 4 weeks then weekly times 4 weeks that residents have attended and that the care plan was documented in the medical record. Administrator will review the plan during Quality Assurance committee meetings times 2 months and continue audits at the discretion of the committee.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, a physician's telephone interview, and record review, the facility failed to accurately transcribe a medication order for 1 of 5 residents (Resident #23) reviewed for unnecessary medications. The transcription error resulted in Resident #23 missing two days of a steroid medication and receiving an extra dose of the steroid on two subsequent days.	F 658	Regarding the alleged deficient practice of the failure to meet professional standards to accurately transcribe a medication as evidenced by: - Resident #23 missed two days of a steroid medication and received an extra dose of the steroid on two subsequent days due to a medication transcription error.	12/16/23

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F 658	Continued From page 5 The findings included: Resident #23 was admitted to the facility on 4/6/23 from a hospital. His cumulative diagnoses included diabetes and a history of cerebrovascular accident (stroke). The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 8/6/23. Staff assessed Resident #23's cognitive status and reported he had "modified independence" for daily decision making with some difficulty in new situations only. A review of Resident #23's electronic medical record (EMR) revealed a physician's order was received on 10/30/23 for 10 milligrams (mg) prednisone (an oral corticosteroid medication) to be administered according to the following schedule: --Give 6 tablets by mouth one time a day times 2 days for dermatitis; --Give 4 tablets by mouth one time a day times 2 days for dermatitis; --Give 3 tablets by mouth one time a day times 2 days for dermatitis; --Give 2 tablets by mouth one time a day times 2 days for dermatitis; --Give 1 tablet by mouth one time a day times 2 days for dermatitis. The physician order indicated the start date for this prednisone taper was 10/31/23 and the end date was 11/10/23. A prednisone taper typically involved a gradual lowering of the steroid dose. The 10/30/23 physician orders for the prednisone taper were entered into the computer system by Nurse #2. A review of the orders revealed they were entered as follows:	F 658	Medication Error report was completed on 11/16/23 by the Nurse Unit Manager, including notification to the resident, and notification to the provider with no new orders or recommendations given. The transcribing nurse was provided education by the Director of Nursing on 11/16/23 on transcribing orders accurately. All residents have the potential to be affected. The Staff Development Coordinator will educate all nurses on the importance of accurately transcribing provider orders by 12/16/23, or will be required to complete the education prior to taking an assignment if not completed by 12/16/23. A second check of provider orders will be reviewed the next business day by the interdisciplinary team during the weekday clinical meeting. This meeting includes nursing management and the Medical Director who is present 4 days a week. The nurse management staff and Medical Director will review new orders to ensure that the problem does not occur. Director of Nursing or designee will audit transcription orders for accuracy 3 days a week on two residents times 4 weeks then weekly times 4 weeks. Director of Nursing will review the plan during Quality Assurance committee meetings times 2 months and continue audits at the discretion of the committee.	

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--On 10/31/23 and 11/1/23, 6 tablets (60 mg) of prednisone were scheduled to be given to the resident one time a day.
--On 11/2/23 and 11/3/23, 4 tablets (40 mg) of prednisone were scheduled to be given to the resident one time a day.
--On 11/4/23 and 11/5/23, 3 tablets (30) of prednisone were scheduled to be given to the resident one time a day.
--On 11/6/23 and 11/7/12, no doses of prednisone were scheduled to be given to Resident #23 for these two days due to an error made in this computer entry. The physician order indicated 2 tablets (20 mg) of prednisone should have been scheduled to be given to the resident on 11/6/23 and 11/7/23.
--On 11/8/23 and 11/9/23, 2 tablets (20 mg) of prednisone were scheduled to be given to the resident one time a day due to an error made in the computer entry for 11/8/23 and 11/9/23.
-- Also on 11/8/23 and 11/9/23, 1 tablet (10 mg) of prednisone was scheduled to be given to the resident one time a day.

Resident #23's electronic Medication Administration Records (MARs) from October 2023 and November 2023 were reviewed. The MARs revealed Resident #23 received the following:
--On 10/31/23 and 11/1/23, 6 tablets (60 mg) of prednisone were administered to the resident one time a day.
--On 11/2/23 and 11/3/23, 4 tablets (40 mg) of prednisone were administered to the resident one time a day.
--On 11/4/23 and 11/5/23, 3 tablets (30 mg) of prednisone were administered to the resident one time a day.
--On 11/6/23 and 11/7/12, no doses of prednisone

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F 658	Continued From page 7	F 658		

were administered to Resident #23.
--On 11/8/23 and 11/9/23, 2 tablets (20 mg) of prednisone were administered to the resident one time a day. Also on 11/8/23 and 11/9/23, 1 tablet of prednisone (10 mg) was administered to the resident.
Administering the prednisone as erroneously entered into the computer system resulted in Resident #23 failing to receive any doses of prednisone on 11/6/23 and 11/7/23 and receiving a total of 30 mg of prednisone on 11/8/23 and 11/9/23.

An interview was conducted with Nurse #2 on 11/15/23 at 3:25 PM. Nurse #2 was identified by the documentation in Resident #23's EMR as having entered the physician orders for the prednisone taper into the computer system on 10/30/23. During the interview, Nurse #2 reviewed the prednisone orders for Resident #23 and recalled putting these orders into the computer. Upon review, the nurse confirmed she made an error when she entered the orders into the computer and stated it was "a calendar issue." Nurse #2 reported the 2 tablets of 10 mg prednisone should have been entered into the computer to be administered on 11/6/23 and 11/7/23 (instead of 11/8/23 and 11/9/23).

An interview was conducted on 11/16/23 at 10:45 AM with the facility's Director of Nursing (DON). During the interview, the DON was shown Resident #23's November 2023 MAR and the progression of the prednisone taper ordered from 10/31/23 to 11/9/23. When asked what her thoughts were with regards to the error made during transcription of the prednisone doses, the DON stated she would need do a medication error report showing two days of missed

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F 658	Continued From page 8 prednisone doses and two days of prednisone "double dosing." Also, the DON reported she would need to conduct education with the nurses responsible for the computer entry of physician orders and implement a system of "second checks" to minimize the risk of computer entry errors. A telephone interview was conducted on 11/16/23 at 2:13 PM with Resident #23's physician. The physician recalled ordering a prednisone taper to treat Resident #23 systemically (versus topically) for a rash that appeared to be atopic dermatitis. Atopic dermatitis is a common condition that typically causes inflammation, redness, and irritation of the skin. The physician confirmed he was contacted by the facility on this date (11/16/23) and made aware of the medication error that occurred with the resident's prednisone taper. When asked if he would consider the error to have been a significant medication error, the physician stated he did not. However, the physician added that he was not sure how a medication error such as this one could have been made.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure residents' nails were clean and trimmed for 2 of 3 residents (Resident #15 and Resident #6) who	F 677	Regarding the alleged deficient practice of the failure to provide proper nail care for 2 of 3 dependent residents by: - Resident #15 had nails that were	12/16/23

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F 677	Continued From page 9 were reviewed for Activities of Daily Living (ADL). The findings included: 1. Resident #15 was admitted to the facility on 8/13/23 from a hospital. Her cumulative diagnoses included a history of cerebral infarction (a type of stroke which occurs when blood flow to the brain is disrupted) and contractures of her left upper arm. Resident #15's care plan included the following area of focus, in part: The resident has an Activities of Daily Living (ADL) self-care performance deficit related to confusion, cerebrovascular accident (stroke) and left spastic hemiplegia (paralysis on one side of the body). This area of focus was initiated and revised on 9/1/23. A quarterly Minimum Data Set (MDS) assessment dated 10/5/23 indicated Resident #15 had moderately impaired cognition. No behaviors nor rejection of care were reported. The assessment indicated Resident #15 required set-up/clean-up assistance for eating; partial/moderate assistance for personal hygiene and bathing; and substantial/maximal assistance from staff for toileting. An observation was conducted on 11/13/23 at 10:00 AM of Resident #15 as she was lying in her bed. The resident's fingers of her left hand were observed to be contracted into a tight fist and she was holding a brown paper-like substance protruding between two of the fingers. When asked to see her fingernails on the left hand, the resident used her right hand to slightly open the fist of her left hand, revealing her left thumb nail	F 677	considered long and had dark brown substance underneath; and - Resident #6 had nails that were jagged with dark brown substance underneath Both Resident #15 and Resident #6 nails were cleaned and trimmed by the nurse on 11/15/23. All residents have the potential to be affected. On 12/15/23, all residents were audited for nail care and care was provided as wanted and needed for safety by two designated CNAs. The Staff Development Coordinator will educate all clinical staff about personal hygiene and for nail care to be provided as wanted by the resident and as needed by 12/16/23, or will be required to complete the education before taking an assignment if not completed by 12/16/23. Nail care will be offered and provided routinely by nursing staff and on an as needed basis to ensure resident's nails are at a safe length and that nails are clean. The Director of Nursing or designee will audit resident nail care and cleanliness three times a week on 5 residents times 4 weeks, then once a week on 3 residents times 4 weeks. Director of Nursing will review the plan during Quality Assurance committee meetings times 2 months and continue audits at the discretion of the committee.	

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F 677	Continued From page 10	F 677		

as the protrusion that had been observed between the fingers of her left hand. No cuts or abrasions were observed on the resident's palm or fingers of her left hand. Resident #15's left thumbnail appeared to be approximately 3/8" long with a dark brown substance present underneath the nail. The nail on the little finger of her left hand (the only other nail visible at that time) was ¼" long with a black/brown substance observed to be present under that nail. The fingernails on the resident's right hand were observed to be 1/8-1/4" long with a black/brown substance observed under each one. At the time of this observation, Resident #15 stated, "I wish they would trim and clean my nails."

Another observation was conducted of Resident #15 on 11/15/23 at 11:17 AM. At that time, the resident was observed to be lying in her bed with both of her hands visible. Her left hand was tightly contracted into a fist, leaving the fingernails on her thumb, 4th, and 5th digit as the only nails visible on that hand. The fingernail on her left thumb was approximately 3/8" long with the nail on her left 4th and 5th digits approximately 1/4" long. The fingernails on her right hand were 1/8-1/4" long. Both hands had a dark brown substance under the nails. When asked if the staff would clean and trim her nails if she wanted them to, the resident stated, "If they have time."

Accompanied by the Nurse Aide (NA) #1, an observation and interview were conducted on 11/15/23 at 4:30 PM of Resident #15's fingernails. NA #1 was identified as the nurse aide assigned to care for the resident. After observing Resident #15's fingernails, the NA was asked what her thoughts were. She stated, "They need to be cut, they are too long." The NA reported that a nurse

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was the only one who could trim the resident's fingernails.

On 11/15/23 at 4:40 PM, Nurse #4 was asked to observe Resident #15's fingernails. Nurse #4 was the hall nurse assigned to care for the resident. Accompanied by Nurse #4, another observation was conducted of Resident #15's fingernails. Upon observing the resident's nails, the nurse stated her fingernails needed to be cut. She reported she would trim Resident #15's fingernails today. The nurse added, "She (the resident) hasn't been up here (on the 200 Hall) that long." In a follow-up interview conducted with the nurse on 11/15/23 at 4:45 PM, the hall nurse reported the NAs should report to the hall nurse when a resident's fingernails needed to be cut.

An interview was conducted on 11/16/23 at 10:45 AM with the facility's Director of Nursing (DON) regarding Resident #15's ADL care and observations of her long fingernails. The DON stated she was new to the facility. However, she reported she was already aware there were concerns regarding grooming for the residents. The DON stated these issues would be addressed.

2. Resident #6 was admitted to the facility on 6/22/2022 with diagnoses that included vascular dementia.

A review of the quarterly Minimum Data Set (MDS) dated 8/26/2023 revealed Resident #6 had moderate cognitive impairment and required extensive assistance of one staff member with personal hygiene and total assistance of one staff member for bathing. The Resident had no

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rejection of care identified during the look back period.

A review of the care plan dated 9/8/2023 identified a focused area that Resident #6 had an activities of daily living (ADL) self-care performance deficit related to impaired mobility and dementia. The interventions included the Resident required extensive assist with personal hygiene.

An observation was conducted on 11/13/2023 at 10:42 a.m. of Resident #6. She was lying in her bed with a blanket pulled up to her chin, being gripped by her hands. Her fingernails were observed to be ½ centimeter (cm) in length with jagged edges on her left middle, index, and pointer finger. There was a dark brown substance under each of her nails.

An observation was conducted during a medication pass observation, on 11/15/2023 at 7:50 a.m. of Resident #06. The Resident reached out to take the medication cup with her right hand, her nails were ½ cm long with a dark brown/black substance underneath the nails.

An observation was conducted on 11/15/2023 at 4:52 p.m. of Resident #06 and she was observed to have nails on both hands that were ½ cm in length with jagged edges on her left middle, index, and pointer finger. There was a dark brown substance under her nails.

An interview was conducted with Nursing Assistant (NA) #2 on 11/15/2023 at 4:52 p.m. She revealed she was the assigned NA for Resident #06. She was present during an observation of Resident #06's fingernails at that time and stated

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F 677	Continued From page 13 she observed fingernails that were ½ cm in length with jagged edges on her left middle, index, and pointer finger with a dark brown substance under her nail. When asked what staff were responsible for providing nail care, she stated this was the responsibility of the activities staff. She added the dirty areas under the nail should be cleansed by the clinical staff.	F 677		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 756		12/16/23

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F 756	Continued From page 14 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews, consultant pharmacist interview, and record reviews, the facility failed to address recommendations made by the consultant pharmacist based on the monthly Medication Regimen Review (MRR) for 1 of 5 residents reviewed for unnecessary medications (Resident #37). The findings included: Resident #37 was admitted to the facility on 6/2/22 with cumulative diagnoses which included a history of cerebral infarction (a type of stroke which occurs when blood flow to the brain is disrupted), chronic obstructive pulmonary disease (COPD), recurrent major depressive disorder, anxiety disorder, and gastrointestinal reflux disease (GERD). A review of the resident's electronic medical record (EMR) included the following physician orders, in part: --40 milligrams (mg) pantoprazole (a medication used to treat acid reflux) to be administered as 1 tablet by mouth one time a day for GERD (Start Date 6/3/22); --30 mg mirtazapine (an antidepressant	F 756	Regarding the alleged deficient practice of the failure to address pharmacy consultant recommendations as evidenced by: - Resident #37 not having a physician response documented on consultant pharmacy recommendations in his medical chart The primary attending physician is no longer treating residents at the facility. All December Medication Regimen Reviews (MRRs) were reviewed by the Director of Nursing upon receipt from the pharmacy. The current Medical Director will review the MRRs and enter in new orders on residents by 12/18/23. The facility consulting pharmacist will attend the next QA meeting in person during the last week of December to meet the new Medical Director and discuss further needs to prevent previous barriers that were occurring. The new Medical Director is at the facility four times a week and is actively involved in reviewing medication regimens and consults to provide the best quality of care to residents to protect	

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F 756	Continued From page 15 medication) to be administered as 1 tablet by mouth at bedtime for depression (Start Date 6/3/22); --5 mg buspirone (an antianxiety medication) to be administered as 1 tablet by mouth two times a day for anxiety (Start Date 6/4/22); --100/62.5/25 micrograms (mcg) per inhalation of fluticasone-umeclidinium-vilanterol (a combination medication containing a steroid medication used to manage COPD) to be administered as one puff inhaled orally one time a day for respiratory disease (Start Date 9/29/22). Resident #37's EMR revealed the facility's consultant pharmacist conducted monthly Medication Regimen Reviews (MRRs). A review of the pharmacist's monthly MRR progress notes from November 2022 to October 2023 included a note dated 11/8/22 which read: "Medical Record Reviewed including orders, available labs, progress notes. See consultant pharmacist report for consult if any irregularities and/or recommendations." Further review of Resident #37's EMR revealed no consultant pharmacist reports from November 2022 were included in his medical record. Upon request, a copy of the consultant pharmacist reports for Resident #37 from November 2022 to October 2023 was provided by the facility for review. This review revealed a consultant pharmacist report dated 11/10/22 recommended the need for the continued use of pantoprazole be addressed and documentation provided if a dose reduction was contraindicated. No physician response was documented on the consultant pharmacist report. Resident #37's EMR provided documentation to indicate his pantoprazole was continued at the same dose	F 756	residents in similar situations. All residents have the potential to be affected. On 11/16/23, the Regional Nurse Consultant educated the Director of Nursing regarding the monthly pharmacy consult recommendation process. Effective immediately, the pharmacist will communicate any irregularities of regimen reviews to the facility and attending physician by verbal or written communication. The Director of Nursing and Medical Director will then review the findings and the Medical Director will make changes to current orders as deemed appropriate and input new orders and or documentation as needed. Director of Nursing or designee will audit monthly drug pharmacy recommendations times 3 months to ensure drug regimen reviews are being conducted by the Medical Director. Director of Nursing and consulting pharmacist will review the plan during Quality Assurance committee meetings times 3 months and continue audits at the discretion of the committee.	

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until 8/17/23.

A review of the pharmacist's monthly MRR progress note dated 12/6/22 read: "Medical Record Reviewed including orders, available labs, progress notes. See consultant pharmacist report for consult if any irregularities and/or recommendations." Further review of Resident #37's EMR revealed no consultant pharmacist reports from December 2022 were included in his medical record.

Upon request, a copy of the consultant pharmacist reports for Resident #37 was provided by the facility for review. This review revealed a consultant pharmacist report dated 12/7/22 recommended the physician review the resident's mirtazapine for a possible dose reduction. No physician response was documented on the consultant pharmacist report. Resident #37's EMR provided documentation to indicate his mirtazapine was continued at the same dose until 11/3/23.

A review of the pharmacist's monthly MRR progress note dated 1/9/23 read: "Medical Record Reviewed including orders, available labs, progress notes. See consultant pharmacist report for consult if any irregularities and/or recommendations." Further review of Resident #37's EMR revealed no consultant pharmacist reports from January 2023 were included in his medical record.

Upon request, a copy of the consultant pharmacist reports for Resident #37 was provided by the facility for review. This review revealed a consultant pharmacist report dated 1/11/23 recommended consideration of adding

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a note to "rinse mouth after use" of the resident's fluticasone-umeclidinium-vilanterol inhaler. The pharmacist noted that rinsing after corticosteroid inhalers reduced oral candidiasis (a fungal infection) per manufacturer's guidelines. No response was documented on the consultant pharmacist report. Resident #37's EMR provided documentation to indicate additional instructions were not added to the physician's order for the resident's fluticasone-umeclidinium-vilanterol inhaler to "rinse mouth after use" as of the date of the review (11/16/23).

The pharmacist's monthly MRR progress notes dated 2/1/23 and 3/2/23 each read: "Medical Record Reviewed including orders, available labs, progress notes. See consultant pharmacist report for consult if any irregularities and/or recommendations." Further review of Resident #37's EMR revealed no consultant pharmacist reports from either February 2023 or March 2023 were included in his medical record. Upon request, a copy of the consultant pharmacist reports for Resident #37 was provided by the facility for review. There were no consultant pharmacist reports identified for February 2023 or March 2023.

A review of the pharmacist's monthly MRR progress note dated 4/11/23 read: "Medical Record Reviewed including orders, available labs, progress notes. See consultant pharmacist report for consult if any irregularities and/or recommendations." Further review of Resident #37's EMR revealed no consultant pharmacist reports from April 2023 were included in his medical record.

Upon request, a copy of the consultant

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pharmacist reports for Resident #37 was provided by the facility for review. This review revealed a consultant pharmacist report dated 4/12/23 recommended the physician consider addressing the possibility of a gradual dose reduction for Resident #37's mirtazapine and buspirone. No physician response was documented on the consultant pharmacist report. Resident #37's EMR provided documentation to indicate the resident's mirtazapine was continued at the same dose until 11/3/23 and his buspirone continued at the same dose as of the date of the review (11/16/23).

A pharmacist's monthly MRR progress note dated 5/3/23 read: "Medical Record Reviewed including orders, available labs, progress notes. See consultant pharmacist report for consult if any irregularities and/or recommendations." Further review of Resident #37's EMR revealed no consultant pharmacist reports from May 2023 were included in his medical record. Upon request, a copy of the consultant pharmacist reports for Resident #37 was provided by the facility for review. There were no consultant pharmacist reports identified for May 2023.

A review of the pharmacist's monthly MRR progress note dated 6/1/23 read: "Medical Record Reviewed including orders, available labs, progress notes. See consultant pharmacist report for consult if any irregularities and/or recommendations." Further review of Resident #37's EMR revealed no consultant pharmacist reports from June 2023 were included in his medical record.

Upon request, a copy of the consultant pharmacist reports for Resident #37 was

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provided by the facility for review. This review revealed a consultant pharmacist report dated 6/2/23 recommended the physician consider a trial dose reduction of Resident #37's buspirone. No physician response was documented on the consultant pharmacist report. Resident #37's EMR provided documentation to indicate the resident's buspirone continued at the same dose as of the date of the review (11/16/23).

The pharmacist's monthly MRR progress notes dated 7/2/23, 8/1/23, 9/4/23 and 10/3/23 each read: "Medical Record Reviewed including orders, available labs, progress notes. See consultant pharmacist report for consult if any irregularities and/or recommendations." Further review of Resident #37's EMR revealed no consultant pharmacist reports from July 2023 through October 2023 were included in his medical record. Upon request, a copy of the consultant pharmacist reports for Resident #37 was provided by the facility for review. There were no consultant pharmacist reports with physician recommendations identified for July 2023 through October 2023.

A telephone interview was conducted on 11/16/23 at 1:20 PM with the facility's consultant pharmacist. The consultant pharmacist reported both she and a partner pharmacist consulted to the facility for a little over one year. She stated a report was provided to the facility each month which listed all the residents reviewed by the pharmacist. The monthly report also identified which residents had a pharmacist consultation report completed with recommendations made to the physician. She reported the facility's failure to address recommendations made in the consultant pharmacist reports was a concern.

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The pharmacist also stated each month the facility was made aware of any outstanding recommendations that had not yet been acknowledged. The pharmacist gave an example by stating that in July 2023, only 10% of the recommendations made by the pharmacist had been addressed by the facility.

An interview was conducted on 11/16/23 at 10:45 AM with the facility's Director of Nursing (DON). The DON reported she was new to the facility (within the last week). The DON stated she had been made aware the consultant pharmacist's reports were not signed by the provider, and it was her understanding that the pharmacist's recommendations "were not done" prior to her coming to the facility. At that time, the DON described the process that she would expect to be followed to appropriately address these recommendations. The DON reported after she received the pharmacist's recommendations, she would need to make two copies (one for herself and one for the provider). She would then pass the pharmacist's recommendation(s) to the provider. After the recommendation(s) were reviewed by the provider and accepted or rejected, they would be given back to her so she could compare the signed consultation form(s) with what she had to be sure all the recommendations were addressed. The DON stated she would then take care of any necessary changes made by the provider, make sure the orders were put into the computer as needed, then fax the completed forms back to the pharmacist. The DON would be responsible for giving these completed forms to medical records so they could be scanned into the resident's EMR.

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F 759	Continued From page 21	F 759		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and the consultant pharmacist, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 5 medication errors out of 30 opportunities, resulting in a medication error rate of 16.6% for 3 of 7 residents (Residents #6, #210, and #4) observed during the medication administration observation. The findings included: 1-a. Resident #6 was admitted to the facility on 6/22/22. Her cumulative diagnoses included a history of hypertension and constipation. On 11/15/23 at 7:50 AM, Nurse #4 was observed as she checked Resident #6's vital signs. Her vital signs included a blood pressure of 125 / 68 and pulse rate of 54 beats per minute (bpm). After the resident's vital signs were taken, Nurse #4 reported she was going to hold the resident's amlodipine (a blood pressure medication) based on the vital sign parameters written by her physician and included in her orders. The nurse was then observed as she prepared and administered 5 other oral medications to Resident #6. A review of Resident #6's medication (med)	F 759	Regarding the alleged deficient practice of the failure to receive a medication error rate of 5% or less as evidenced by: - 5 medication errors out of 30 opportunities, resulting in 16.6% medication error rate The Medical Director was called on 11/15/23 by the Unit Manager and was made aware of all medication errors with no new orders given for any affected resident. Immediate in-services were conducted during the survey to reduce the medication error rate. All residents have the potential to be affected. Staff Development Coordinator to verbally in-service all licensed staff including 5 rights, medication parameters, nursing judgment, and reading orders, and all nurses and medication aides to complete updated competencies by 12/16/23, or will be required to complete the education before taking an assignment if not completed by 12/16/23. Director of Nursing or designee will audit 3 resident medication passes 3 days a week times 4 weeks then 1 resident	12/16/23

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F 759	Continued From page 22 orders revealed the resident had a current order initiated on 6/23/22 for 10 milligrams (mg) amlodipine to be given as one tablet by mouth one time a day for hypertension. The order also included instructions to hold the amlodipine for a systolic blood pressure less than 110. Systolic blood pressure is the maximum pressure the heart exerts while beating and is represented by the top number of a blood pressure reading. An interview was conducted with Nurse #4 on 11/15/23 at 12:22 PM. At that time, the nurse was asked to review the physician's order for amlodipine on Resident #6's November 2023 Medication Administration Record (MAR) and vital signs taken at the time of the medication administration observation earlier that morning. When she reviewed the MAR, vital sign results, and parameters of the order for Resident #6's amlodipine, Nurse #4 confirmed the resident's systolic blood pressure was greater than 110 and according to the current physician orders, the resident's amlodipine should have been administered to her. An interview was conducted with the 200 Unit Manager on 11/15/23 at 12:34 PM. During the interview, the morning medication administration observation for Resident #6 was discussed. The Unit Manager reviewed the physician orders and confirmed the resident's blood pressure medications (including amlodipine) should have been administered because her systolic blood pressure was 125 (greater than 110). The Unit Manager reported if the nurse had a concern about the administration of these medications, she would have wanted her to either come to her to discuss the concerns or call the provider directly for further guidance and a possible	F 759	medication pass 2 days a week times 4 weeks. This will include nurses and medication aides on after hour shifts and different days of the week to monitor performance and ensure compliance. Director of Nursing will review the plan during Quality Assurance committee meetings times 2 months and continue audits at the discretion of the committee.	

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change in the vital sign parameters, if needed.

An interview was conducted with the facility's Director of Nursing (DON) on 11/15/23 at 1:50 PM. During the interview, the medication administration observations were discussed. The DON reported if Nurse #4 wanted to hold Resident #6's antihypertensive medications per nursing judgement, she should have called the physician to get an order to either hold or give the medication and to clarify the order, if needed. If the nurse still did not feel comfortable giving the medication, the DON would have wanted her to discuss the issue with either her or the Unit Manager.

1-b. Resident #6 was admitted to the facility on 6/22/22. Her cumulative diagnoses included a history of hypertension and constipation.

On 11/15/23 at 7:50 AM, Nurse #4 was observed as she checked Resident #6's vital signs. Her vital signs included a blood pressure of 125 / 68 and pulse rate of 54 beats per minute (bpm). After the resident's vital signs were taken, Nurse #4 reported she was going to hold the resident's lisinopril (a blood pressure medication) based on the vital sign parameters written by her physician and included in her orders. The nurse was then observed as she prepared and administered 5 other oral medications to Resident #6.

A review of Resident #6's medication (med) orders revealed the resident had a current order initiated on 6/23/22 for 10 milligrams (mg) lisinopril to be given as one tablet by mouth one time a day for hypertension. The order also included instructions to hold the lisinopril for a systolic blood pressure less than 110. Systolic

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blood pressure is the maximum pressure the heart exerts while beating and is represented by the top number of a blood pressure reading.

An interview was conducted with Nurse #4 on 11/15/23 at 12:22 PM. At that time, the nurse was asked to review the physician's order for lisinopril on Resident #6's November 2023 Medication Administration Record (MAR) and vital signs taken at the time of the medication administration observation earlier that morning. When she reviewed the MAR, vital sign results, and parameters of the order for Resident #6's lisinopril, Nurse #4 confirmed the resident's systolic blood pressure was greater than 110 and according to the current physician orders, the resident's lisinopril should have been administered to her.

An interview was conducted with the 200 Unit Manager on 11/15/23 at 12:34 PM. During the interview, the morning medication administration observation for Resident #6 was discussed. The Unit Manager reviewed the physician orders and confirmed the resident's blood pressure medications (including lisinopril) should have been administered because her systolic blood pressure was 125 (greater than 110). The Unit Manager reported if the nurse had a concern about the administration of these medications, she would have wanted her to either come to her to discuss the concerns or call the provider directly for further guidance and a possible change in the vital sign parameters, if needed.

An interview was conducted with the facility's Director of Nursing (DON) on 11/15/23 at 1:50 PM. During the interview, the medication administration observations were discussed. The

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DON reported if Nurse #4 wanted to hold Resident #6's antihypertensive medications per nursing judgement, she should have called the physician to get an order to either hold or give the medication and to clarify the order, if needed. If the nurse still did not feel comfortable giving the medication, the DON would have wanted her to discuss the issue with either her or the Unit Manager.

1-c. Resident #6 was admitted to the facility on 6/22/22. Her cumulative diagnoses included a history of hypertension and constipation.

On 11/15/23 at 7:50 AM, Nurse #4 was observed as she prepared and administered 5 oral medications to Resident #6. The oral medications administered included two tablets of 8.6 milligrams (mg) sennosides (a laxative) taken from a stock bottle on the medication cart.

A review of Resident #6's medication orders revealed the resident had a current order initiated on 6/23/22 for 8.6 mg sennosides / 50 mg docusate (a combination medication containing a laxative with a stool softener) to be administered as two tablets by mouth every day for constipation.

An interview was conducted with Nurse #4 on 11/15/23 at 12:22 PM. Upon request, Nurse #4 reviewed Resident #6's November 2023 Medication Administration Record (MAR) and pulled out of the medication (med) cart drawer the stock bottle she used earlier that morning to obtain the sennosides tablet. During the interview, the nurse acknowledged the sennosides medication administered to the resident was not the combination medication

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ordered by the Medical Doctor (MD). Nurse #4 checked the stock medications on the med cart and confirmed a stock bottle containing a combination medication of 8.6 mg sennosides / 50 mg docusate was available on the cart.

An interview was conducted with the facility's Director of Nursing (DON) on 11/15/23 at 1:50 PM. During the interview, the medication administration observations were discussed. The DON reported nursing staff administering medications to a resident needed to pay closer attention to the combination meds and dosages of each. She stressed the importance of nursing staff following the 5 rights of medication administration (right patient, right drug, right dose, right route of administration, and right time).

2. Resident #210 was admitted to the facility on 11/3/23. His cumulative diagnoses included a history of cerebral infarction (stroke) and myocardial infarction (heart attack).

On 11/15/23 at 8:40 AM, Nurse #7 was observed as she prepared and administered 12 oral medications to Resident #210. The oral medications administered included one (1) chewable tablet of 81 milligram (mg) aspirin taken from a stock bottle on the medication cart.

A review of Resident #210's medication (med) orders revealed the resident had a current order initiated on 11/10/23 for four (4) chewable tablets of 81 mg aspirin to be administered one time a day as an antiplatelet medication.

An interview was conducted with Nurse #7 on 11/15/23 at 11:04 AM. Upon request, Nurse #7 reviewed Resident #210's November 2023

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Medication Administration Record (MAR). During the interview, the nurse confirmed the order for 81 mg aspirin was for 4 tablets instead of the one tablet she was observed to administer earlier that morning. The nurse stated she would need to administer the remaining 3 tablets of 81 mg aspirin chewable tablets to the resident.

An interview was conducted with the facility's Director of Nursing (DON) on 11/15/23 at 1:50 PM. During the interview, the medication administration observations were discussed. The DON reported nursing staff administering medications to a resident needed to pay closer attention to the combination meds and dosages of each. She stressed the importance of nursing staff following the 5 rights of medication administration (right patient, right drug, right dose, right route of administration, and right time).

3. Resident #4 was admitted to the facility on 2/13/23. His cumulative diagnoses included chronic kidney disease.

On 11/15/23 at 8:19 AM, Nurse #6 was observed as she prepared and administered 3 oral medications to Resident #4. The oral medications administered included one tablet of 600 milligrams (mg) calcium / 400 units Vitamin D (a combination medication) taken from a stock bottle stored on the medication cart.

A review of Resident #4's medication (med) orders revealed the resident had a current order initiated on 2/16/23 for 600 mg calcium carbonate tablet (not a combination medication) to be administered as one tablet by mouth two times a day for hypocalcemia (low levels of calcium in the blood). The resident's med orders also included

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F 759	Continued From page 28 a current (but separate) order for 50,000 units of Vitamin D3 to be administered as one tablet by mouth once every 7 days. An interview was conducted with Nurse #6 on 11/15/23 at 11:07 AM. Upon request, Nurse #6 reviewed Resident #4's November 2023 Medication Administration Record (MAR). At that time, Nurse #6 stated she later realized she had given the resident calcium with "extra" Vitamin D. The nurse reported the correct calcium dose (without the Vitamin D) was available on the med cart. She stated, "I grabbed the wrong bottle." An interview was conducted with the facility's Director of Nursing (DON) on 11/15/23 at 1:50 PM. During the interview, the medication administration observations were discussed. The DON reported nursing staff administering medications to a resident needed to pay closer attention to the combination meds and dosages of each. She stressed the importance of nursing staff following the 5 rights of medication administration (right patient, right drug, right dose, right route of administration, and right time).	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		12/16/23

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F 761	Continued From page 29 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record reviews, the facility failed to: 1) Accurately label medications (meds) to determine their shortened expiration date in accordance with the manufacturer's instructions on 2 of 2 med carts (Med Cart for Rooms 200 - 209 and Med Cart for the 100 Front Hall); 2) Discard expired medications and/or meds without a legible expiration date on 2 of 2 medication carts (Med Cart for Rooms 200 - 209 and Med Cart for the 100 Front Hall); 3) Label medications with the minimum information required, including the name of the resident, on 1 of 2 medication carts (Med Cart for the 100 Front Hall) observed; 4) Store medications in accordance with the manufacturer's storage instructions on 2 of 2 medication carts (Med Cart for Rooms 200 - 209 and Med Cart for the 100 Front Hall) observed. The findings included: 1. An observation was conducted on 11/13/23 at	F 761	Regarding the alleged deficient practice of the failure for labeling and storing medications as evidenced by: - Storage and labeling of insulin pens - Discard expired medication without a legible expiration date - Label medications with minimum resident information required All medication carts were audited at the time of the findings on 11/13/23 and areas were corrected for labeling to ensure no other residents were affected. Immediate verbal instruction in-services were conducted by the Staff Development Coordinator and Director of Nursing. All residents have the potential to be affected. The Staff Development Coordinator will verbally in-service all licensed staff on dating medications, five rights to medication, and medication	

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F 761	Continued From page 30 3:35 PM in the presence of Nurse #4 of the Medication (Med) Cart for Rooms 200-209. The observation revealed the following medications were stored on the med cart: a. An opened Novolog insulin FlexPen dispensed for Resident #3 was observed to be placed in a plastic bag labeled by the pharmacy for Resident # 44. The plastic bag also contained an insulin pen for Resident #44. A pharmacy auxiliary sticker placed on Resident #3's insulin pen included two blanks; one blank to hand-write the date the insulin was opened and the second blank to note the date the insulin expired. The auxiliary sticker also read, "Discard After 28 Days." Resident #3's Novolog insulin FlexPen was not dated as to when it had been opened to allow for a determination of its shortened expiration date. According to the product manufacturer, in-use Novolog FlexPens should be stored at room temperature less than 86o Fahrenheit (o F) and used within 28 days. b. An opened Humalog KwikPen dispensed for Resident # 261 was stored on the med cart. A hand-written note on a pharmacy auxiliary sticker adhered to the insulin pen indicated the pen was opened on 8/23/23. The shortened expiration date for the Humalog KwikPen was not written on the auxiliary sticker. The pharmacy auxiliary sticker read, "Discard After 28 Days." The Humalog KwikPen had been open for 82 days as of the date of the observation conducted on 11/13/23. According to the product manufacturer, in-use Humalog KwikPens should be stored at room	F 761	storage, to include inhaled solutions by 12/16/23, or will be required to complete the education prior to taking an assignment if not completed by 12/16/23. The Director of Nursing or designee will audit 4 medication carts a week times 4 weeks. Then 2 carts a week times 4 weeks to ensure labeling and dating accuracy. Director of Nursing will review the plan during Quality Assurance committee meetings times 2 months and continue audits at the discretion of the committee.	

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temperature (less than 86o F) and used within 28 days.

c. An opened insulin glargine pen dispensed for Resident #44 on 9/29/23 was stored on the med cart. A pharmacy auxiliary sticker placed on Resident #44's insulin pen included two blanks; one blank to hand-write the date the insulin was opened and the second blank to note the date the insulin expired. The auxiliary sticker also read, "Discard After 28 Days." Resident #44's insulin glargine pen was not dated as to when it had been opened to allow for a determination of its shortened expiration date.

According to the product manufacturer, in-use insulin glargine pens should be stored at room temperature (less than 86o F) and used within 28 days.

d. An opened Humulin 70/30 KwikPen dispensed for Resident #15 on 9/10/23 was stored on the med cart. A hand-written notation on the pharmacy label adhered to a plastic bag containing the pen read, "10/1/23." A pharmacy auxiliary sticker adhered to the insulin pen indicated the pen was opened on 10/1/23. The shortened expiration date for the Humulin 70/30 KwikPen was not written on the auxiliary sticker.

According to the product manufacturer, when stored at room temperature, Humulin 70/30 KwikPen can only be used for a total of 10 days including both not in-use (unopened) and in-use (opened) storage time. Resident #15's Humulin 70/30 KwikPen had been opened for 43 days as of the date of the observation conducted on 11/13/23.

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e. An opened vial of Humulin R (Regular) insulin dispensed for Resident #39 on 10/1/23 was stored on the med cart. A pharmacy auxiliary sticker placed on Resident #39's insulin vial included two blanks; one blank to hand-write the date the insulin was opened and the second blank to note the date the insulin expired. The auxiliary sticker also read, "Discard After 28 Days." Resident #39's vial of insulin was not dated as to when it had been opened to allow for a determination of its shortened expiration date.

According to the product manufacturer, an opened vial of Humulin R insulin may be stored under refrigeration (between 36o and 46o F) or at room temperature (less than or equal to 86o F) and should be used within 28 days.

f. An opened Humalog KwikPen dispensed for Resident #7 on 9/29/23 was stored on the med cart. A pharmacy auxiliary sticker adhered to the insulin pen indicated the pen was opened on 10/13/23. The shortened expiration date for the Humalog KwikPen was not written on the auxiliary sticker. The pharmacy auxiliary sticker read, "Discard After 28 Days." The Humalog KwikPen had been open for 31 days as of the date of the observation conducted on 11/13/23.

According to the product manufacturer, in-use Humalog KwikPens should be stored at room temperature (less than 86o F) and used within 28 days.

g. An opened vial of Humulin N (an intermediate-acting insulin) dispensed for Resident #39 was stored on the med cart. The pharmacy dispensed date was not legible on the insulin's label. A pharmacy auxiliary sticker

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placed on Resident #39's insulin pen included two blanks; one blank to hand-write the date the insulin was opened and the second blank to note the date the insulin expired. The auxiliary sticker also read, "Discard After 28 Days." Resident #39's Humulin N insulin vial was not dated as to when it had been opened to allow for a determination of its shortened expiration date.

According to the product manufacturer, in-use Humulin N vials may be stored under refrigeration (between 36o and 46o F) or at room temperature (less than or equal to 86o F) and should be used within 31 days.

An interview was conducted with Nurse #4 on 11/13/23 at 4:05 PM. Upon inquiry, the nurse reported an insulin vial or insulin pen should be dated when it was put on the cart and used. When asked, she stated the insulin's expiration date should also be written on the pharmacy auxiliary sticker.

An interview was conducted on 11/15/23 at 1:42 PM with the facility's Director of Nursing (DON). The DON stated all medications dispensed from the pharmacy should be labeled with the minimum required information, including the resident's name. During the interview, the DON also discussed the storage and dating of insulin. She stated unopened pens and vials of insulin should be stored in the Med Room refrigerator. The DON also reported she would expect nursing staff to write both the date an insulin vial or pen was opened and the medication's shortened expiration date on the label of the insulin.

2. An observation was conducted on 11/13/23 at 4:15 PM in the presence of the 100 Hall Unit

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Manager of the 100 Front Hall Medication (Med) Cart. The observation revealed the following medications were stored on the med cart:

a. An opened Novolog insulin FlexPen stored on the med cart was labeled with a room number only written on the insulin pen. The insulin pen was not labeled with the minimum information required, including the resident's name. The insulin pen was also not dated as to when it had been opened to allow for a determination of its shortened expiration date.

b. An unopened vial of Humalog insulin dispensed for Resident #210 on 11/2/23 was observed to be stored on the med cart. The pen was not dated as to when it had been placed on the med cart. At the time of the observation, the Unit Manager reported unopened insulin vials and pens should be stored in the Med Room refrigerator until they needed to be put into use.

According to the product manufacturer, an unopened vial of Humalog insulin may be stored under refrigeration (between 36o and 46o F) until the expiration date or at room temperature (less than 86o F) for 28 days.

c. Two individual vials of 0.5 milligrams (mg) / 3 mg ipratropium / albuterol inhalation solution were stored in an undated, open foil pack on the bottom of a drawer of the med cart. The inhalation solution was not labeled with the minimum information required, including the resident's name or the date the foil pack was opened. The manufacturer's storage information printed on the labeling of the open foil pack indicated that once the foil pack was opened, the individual vials should be used within one week.

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F 761	Continued From page 35 At the time of the observation, the Unit Manager reported the vials in the unlabeled foil pouch would need to be discarded. d. An unopened stock bottle of [Brand Name] antioxidant vitamins and minerals containing 60 tablets was stored on the med cart. The unopened stock bottle was outdated with a manufacturer expiration date of 10/2023. The Unit Manager stated the stock bottle was expired and needed to be discarded. An interview was conducted on 11/15/23 at 1:42 PM with the facility's Director of Nursing (DON). The DON stated all medications dispensed from the pharmacy should be labeled with the minimum required information, including the resident's name. During the interview, the DON also discussed the storage and dating of insulin. She stated unopened pens and vials of insulin should be stored in the Med Room refrigerator. The DON also reported she would expect nursing staff to write both the date an insulin vial or pen was opened and the medication's shortened expiration date on the label of the insulin.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective	F 867		12/16/23

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systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and

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implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least

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F 867	Continued From page 38 annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on 6/23/22. This was for 3 deficiencies that were cited in the areas of Accuracy of Assessments (F641), Baseline Care Plans (F655), and Care Plan Timing and Revision (F657) and recited on the current recertification and complaint survey of 11/16/23. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint survey conducted on 5/13/21. This was evident for 1	F 867	The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the facility put into place following the last three federal surveys causing repeated citations in regard to Accuracy of Assessments, Baseline Care Plans, Care Plan Timing and Revision, Services Provided Meet Professional Standard, and Infection Control. Plan of correction was put in to place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools	

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F 867	Continued From page 39 deficiency in the area of Accuracy of Assessments (F641) originally cited on the recertification and complaint survey on 5/13/21 and recited on the current recertification and complaint survey of 11/16/23. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put in place following the complaint survey of 11/22/22. This was evident for 1 deficiency in the area of Services Provided Meet Professional Standards (F658) that was originally cited during a complaint investigation on 11/22/22 and recited on the current recertification and complaint survey of 11/16/23. It was also cited on the complaint survey of 2/24/21. Additionally, the QAA committee failed to maintain implemented procedures and monitor interventions the committee put in place following the complaint survey of 8/12/22. This was evident for 1 deficiency in the area of Infection Control (F880) that was originally cited during a complaint investigation on 8/12/22 and recited on the current recertification and complaint survey of 11/16/23. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The finding included: This citation is cross referred to: F641: During the facility's recertification survey on 11/16/23, the facility failed to accurately code the Minimum Data Set (MDS) assessment related to the Preadmission Screening and Resident Review (PASRR) Level II status for 1 of 1 resident (Resident #37) reviewed with a PASRR	F 867	during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Administrator initiated in-service to administrative staff on 12/14/23 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education. The Quality Assurance Performance Improvement Committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This	

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F 867	Continued From page 40 Level II determination. During the facility's recertification survey of 6/23/22, the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 of 2 residents reviewed for tube feedings. During the facility's recertification survey of 5/13/21, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of restraints and diagnoses for 2 of 5 residents and in the area of discharge status for 1 of 1 resident reviewed for discharge to the community. F655: During the facility's recertification survey on 11/16/23, the facility failed to develop a baseline care plan within 48 hours of a resident's admission and failed to provide a summary of the baseline care plan to the resident for one of one resident (Resident # 58) reviewed for baseline care plan. During the facility's recertification survey of 6/23/22, the facility failed to develop a baseline care plan within 48 hours of admission for 4 of 5 new admissions reviewed. F 657: During the facility's recertification survey on 11/16/23, the facility failed to invite a resident (Resident #30), who was his own responsible party, to a care plan meeting quarterly. This occurred for 1 of 23 residents reviewed for resident specific care plans. During the facility's recertification survey of 6/23/22, the facility failed to update the care plan to reflect the accurate shower schedule and preferences for 2 of 7 residents reviewed for	F 867	process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction.	

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Activities of Daily Living.

F658: During the facility's recertification survey on 11/16/23, the facility failed to accurately transcribe a medication order for 1 of 5 residents (Resident #23) reviewed for unnecessary medications. The transcription error resulted in Resident #23 missing two days of a steroid medication and receiving an extra dose of the steroid on two subsequent days.

During the facility's complaint survey on 11/22/22, the facility failed to obtain and administer prescribed medications to a newly admitted resident that included analgesic medications to treat chronic pain. This occurred for 1 of 3 residents reviewed for pharmacy services.

During the facility's complaint survey on 2/24/21, the facility failed to assess and treat a laceration and a diabetic foot ulcer on a newly admitted resident upon admission for 1 of 3 residents reviewed for skin conditions.

F880: During the facility's recertification survey on 11/16/23, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents in accordance with the instructions provided by the manufacturer of the disinfectant wipes used for 2 of 6 residents whose blood glucose levels were checked (Residents #168 and #58).

During the facility's complaint survey on 8/12/22, the facility failed to adhere to policy and procedures for an enhanced droplet and contact isolation precautions room. One of three staff members observed (Nurse #1) failed to don gloves or gown per signage instructions posted

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F 867	Continued From page 42 on the door. An interview was conducted on 11/16/23 at 10:45 AM with the facility's administrator. She stated that the QA members were made up of Administrator, the Director of Nursing, Dietary Manager, Business office manager, Maintenance Director, Social Worker, Activities Director, and Housekeeping Director. The Nurse Practitioner and the Medical Director were always invited to attend. She stated that both she and the director of nursing were new to the facility but have been made aware of the concerns regarding this survey and the repeat of several citations. She stated that all of the issues will be looked into, and a thorough plan of correction will be drawn up and implemented to ensure these citations would not be repeated again in the future.	F 867		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		12/16/23

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staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 44 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Medical Director interviews, and record reviews, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents in accordance with the instructions provided by the manufacturer of the disinfectant wipes used for 2 of 6 residents whose blood glucose levels were checked (Residents #168 and #58). Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA) approved disinfectant in accordance with the manufacturer of the glucometer creates a high likelihood of exposing residents to the spread of blood borne infections. Immediate Jeopardy began on 11/14/2023 when Nurse #1 was observed during blood glucose testing for three residents on her assigned hall using a shared glucometer between the three residents but did not follow the manufacturer's instructions to allow for the wet contact time as specified for the disinfectant to be effective. Immediate Jeopardy was removed on 11/15/2023 when the facility provided and implemented an acceptable credible allegation of Immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of	F 880	Regarding the alleged deficient practice of the failure to disinfect a shared blood glucose monitor as evidenced by: - Resident #168 blood sugar was checked without cleaning and disinfecting the device according to manufacturer's recommendations prior to testing. Nurse #1 then began walking toward Resident #58's room to check blood sugar with a glucometer that was not cleaned and disinfected according to manufacturer's recommendations and was stopped by the surveyor prior to testing. Facility completed credible allegation and was accepted on 11/15/23. On 11/14/23, The Medical Director was notified of the incident and affected residents and gave no new orders for the involved residents. Nurse #1 was immediately reeducated verbally and by demonstration with return demonstration by the Regional Clinical Director, Director of Nursing, and Staff Development Coordinator on 11/14/23. All residents with a blood sugar order have the potential to be affected. On 11/14/23, Unit Managers and Staff Development Coordinator labeled	

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F 880	Continued From page 45 D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: A review of the facility's policy entitled, "Glucometer Disinfection" (revised 5/2023) read: "The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees." The guidelines included, in part: 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. 2. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected, then the meter will not be used for multiple residents. 3. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against Human immunodeficiency virus (HIV) or Hepatitis B or Hepatitis C virus. 4. The glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. 5. Procedure: a. Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose testing strips,	F 880	individual glucometers for residents with a blood sugar order and stored them in their rooms. On 11/14/23 the Director of Nursing and Staff Development Coordinator began in-servicing all nurses and medication aides on the policy and procedure of cleaning and disinfecting glucometers and for each resident with a blood sugar order to have their own glucometer. The company glucometer policy was put on every medication cart showing the proper procedure on 11/14/23. Any nurse or medication aide found to be sharing glucometers is subject to disciplinary action. All nurses and medication aides who were not in the building at the time of the in-service were called and educated verbally on 11/14/2023. All staff were instructed to see the Director of Nursing and Staff Development Coordinator before their next shift for a return demonstration education. The Staff Development Coordinator arranges all new hire nurses and medication aides. The Staff Development Coordinator will be responsible in keeping up with new staff and they will be in-serviced on glucometer disinfection prior to working on a medication cart and be required to perform a return demonstration by the Director of Nursing or the Staff Development Coordinator. The immediate jeopardy was removed on 11/15/2023. Director of Nursing or designee will audit all residents with blood sugar orders to	

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F 880	Continued From page 46 disinfecting wipes. b. Wash hands. c. Explain the procedure to the resident. d. Provide privacy. e. Put on gloves. f. Obtain capillary blood glucose sampling according to facility policy. g. Remove and discard gloves, perform hand hygiene prior to exiting the room. h. Reapply gloves if there is visible contamination of the device or if the resident is HIV or Hepatitis B or C positive. i. Retrieve (2) disinfectant wipes from container. j. Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. k. After cleaning, use the second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Allow the glucometer to air dry. l. Discard disinfectant wipes in waste receptacle. m. Perform hand hygiene. The manufacturer instructions for the glucometer used at the facility indicated the cleaning and disinfection procedure should be performed after each use on a resident. The disinfecting procedure was needed to prevent the transmission of blood borne pathogens. These instructions read in part, "The (Brand Name) meter should be cleaned and disinfected between each patient." A review of the manufacturer instructions for the disinfectant wipes used to disinfect individual-resident glucometers at the facility read, in part, "Allow treated surface to remain wet for two (2) minutes. Let air dry."	F 880	have their own glucometers three times a week times 4 weeks, then once a week times 4 weeks. Director of Nursing will review the plan during Quality Assurance committee meetings times 2 months and continue audits at the discretion of the committee.	

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	345149	A. BUILDING _____ B. WING _____	C 11/16/2023

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A continuous medication administration observation was conducted with Nurse #1 on 11/14/2023 at 11:30 a.m. The Nurse opened the medication cart, and a single glucometer was observed to be sitting in the top drawer. The glucometer was not labeled with a name and was stored without a covering in the cart. Nurse #1 removed the glucometer, two alcohol wipes, and one lancet from the cart. She placed the supplies on top of the medication cart, performed hand hygiene, and donned a pair of gloves. The Nurse then took the supplies and entered Resident #167's room. She conducted hand hygiene, donned a pair of gloves, cleaned the Resident's finger, placed a droplet on the test strip of the glucometer, and waited for the test results. The glucometer was placed on a bedside table and then on a refrigerator. She then exited the room with the supplies and glucometer. She placed the glucometer on the Medication Cart, discarded the trash she had removed from the room, removed her gloves, conducted hand hygiene, and removed a disinfectant wipe and placed it on the glucometer. The disinfectant wipe touched a portion of the top of the glucometer and did not touch the sides or the underside of the device. She picked up the glucometer and wiped the entire surface for 15 seconds. She placed the device on top of the medication cart to dry. Based on the clock it was allowed to dry for 1 minute. She picked up the device and placed it back in the top drawer of the medication cart. At 11:59 a.m. Nurse #1 removed the glucometer and a container of testing strips from the medication cart, gathered supplies for a blood glucose procedure, conducted hand hygiene, donned a pair of gloves, and entered the room for Resident # 168. She placed the glucometer and the testing

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strips on the bedside table. She cleansed the Resident's finger with an alcohol wipe, used the lancet to prick the skin, placed a droplet of blood on the testing strip of the glucometer. When the test was completed, she picked up the glucometer and the testing strips and then she exited the room. She placed the glucometer and the testing strips on the medication cart, threw the trash away, removed her gloves, removed a disinfectant wipe from the container, and wiped the glucometer for 30 seconds. She then allowed the glucometer to air dry. Based on the clock it was dry in less than one minute. At 12:01 p.m. Nurse #1 had gathered additional glucose testing supplies and went to enter Resident #58's room to perform a blood glucose test. The surveyor stopped the nurse as she was entering the room.

An interview was conducted with Nurse #1 on 11/14/2023 at 12:01 p.m. When asked how long the disinfectant wipe needed to be in contact with the glucometer device, Nurse #1 responded that the disinfectant required two minutes for the solution to be effective. She revealed she was unsure if she had allowed two full minutes. She then reviewed the time she had entered the previous room for Resident #168 and the time she was entering Resident #58's room. She stated the time difference was only two minutes. She added the reason the facility utilized a shared glucometer system was because they had so many residents that come and go quickly and would find peoples blood pressure cuffs and other devices in a new resident's room, so the nurses decided to use only one glucometer. She revealed she received training upon hire at the facility on proper blood glucose cleansing and disinfection of the device.

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An interview was conducted with the Administrator on 11/14/2023 at 1:47 p.m. and she revealed the facility's practice was for each resident to have their own glucometer. She was unsure why the nurses had made the decision to share a glucometer.

An interview was conducted with the Staff Development coordinator/Facility infection preventionist (SDC) on 11/15/2023 at 10:32 a.m. and she revealed the facility policy was to clean a glucometer after each use with an EPA-approved wipe and then use a second wipe for disinfection. The wet contact time should be according to the manufacturer's guidelines. She added this information was provided to all clinical staff that conduct blood glucose readings upon hire and on yearly re-education. She provided a copy of the education provided upon hire, to Nurse #1, dated 11/24/2021.

An interview was conducted with the Medical Director on 11/16/2023 at 2:10 p.m. and he revealed every resident at the facility should have their own glucometer device. He added that sharing a device placed the Residents at risk of contracting a blood borne pathogen like HIV, Hepatitis B, or Hepatitis C. He added it was his expectation that all residents have their own device, and he was not asked if it would be acceptable to share the devices.

A review of the electronic medical record for the medical diagnoses of all current residents at the facility was conducted and no blood borne pathogens were identified.

The facility's Administrator and Director of Nursing were informed of the immediate jeopardy

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(IJ) on 11/14/2023 at 4:47 p.m.

The facility provided the following plan for IJ removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

On 11/14/2023, Nurse #1 checked resident #168 blood sugar without cleaning and disinfecting the device according to manufacturer's recommendations prior to testing. Nurse #1 began walking toward resident #58's room to check blood sugar with a glucometer that was not cleaned and disinfected according to manufacturer's recommendations but was stopped by the surveyor prior to testing. The current census as of 11/14/2023 was printed and any residents that required blood sugar finger sticks were added to the potential affected resident list.

Root cause analysis:

Based on the interview of Nurse #1 she was nervous when the surveyor was standing in observation and did not disinfect the glucometer with 2 disinfectant wipes for the full 2 minutes as indicated by the manufacturer's guide before using it for another resident.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 11/14/2023, The Director of Nursing and Staff Development Coordinator began in-servicing all

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nurses and medication aides on the policy and procedure of cleaning and disinfecting glucometers. All nurses and medication aides that were not in the building at the time of the in-service were called and educated verbally on 11/14/2023. All staff were instructed to see the Director of Nursing and Staff Development Coordinator before their next shift for a return demonstration education. The Staff Development Coordinator arranges all new hire nurses and medication aides. The Staff Development Coordinator will be responsible in keeping up with new staff and they will be in-serviced on glucometer disinfection prior to working on a medication cart and be required to perform a return demonstration by the Director of Nursing or the Staff Development Coordinator.

The county health department was contacted, and messages left. The Medical Director was notified of the incident and affected residents and gave no new orders on 11/14/2023. Nurse #1 was immediately educated verbally and by demonstrating with return demonstration by the Regional Clinical Director, Director of Nursing, and Staff Development Coordinator, on 11/14/2023 on the following:

The glucometer policy was put on every medication cart and shows the following procedure:

1. Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose testing strips, disinfecting wipes.
2. Perform Hand Hygiene
3. Explain the procedure to the resident.
4. Provide privacy.

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5. Don gloves.
6. Obtain capillary blood glucose sampling.
7. Remove and discard gloves, perform hand hygiene prior to exiting the room.
8. Retrieve (2) disinfectant wipes from container.
9. Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer.
10. After cleaning, use the second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions for the dry time. Allow the glucometer to air dry.
11. Discard disinfectant wipes in waste receptacle.
12. Perform hand hygiene.

Education was provided to nurses and medication aides by the Director of Nursing on 11/14/2023 that each resident with a blood sugar order is to have their own individual glucometer. Any nurse or medication aide found to be sharing glucometers is subject to disciplinary action. The Staff Development Coordinator and Unit Managers bagged and labeled the 8 residents without personal glucometers and placed them on their side of the room. Completed on 11/14/2023.

The immediate jeopardy was removed on 11/15/2023.

The facility's credible allegation of immediate jeopardy removal was validated on 11/15/2023. The validation was evidenced by nurse observations and interviews conducted that include the required infection control practices for the use of glucometers. All nurses who were interviewed reported they had received the

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F 880	Continued From page 53 required in-service training and were made aware of the facility's policy to use individually assigned glucometers for each resident requiring blood glucose monitoring. The education included review of the facility's infection control policy, manufacturer instructions related to glucometer disinfection, and a return demonstration. The nurses reported they were informed each resident's individual glucometer was now stored in his or her room. The credible allegation was validated, and the immediate jeopardy was removed on 11/15/2023.	F 880		